Form FE 6-DEP, (4-81)
Office of Federal Employees' Group Life Insurance
4 East 24th Street
New York, New York 10010

Statement of Claim
Option C-Family Life Insurance
Federal Employees' Group Life Insurance

Read instructions on the reverse side of this form before completing form.

Part A — General Information About the Insured

1. Name of insured *(Last, first, middle) (Type or Print)*	2. Date of birth *(Month, day, year)*	3. Social Security Number

4. Department or agency in which employed (include bureau or division)	5. Location of employment *(City, State, ZIP Code)*

6. Are you retired and receiving annuity under any Federal civilian retirement system, including old age and survivors insurance (Social Security)?

☐ Yes, Give → | Retirement claim number | Date of retirement
☐ No

Part B — Information About Deceased Family Member

1. Full name of deceased	2. Date of birth *(Month, day, year)*	3. Date of death *(Month, day, year)*

Complete blanks 4-7 if deceased is your SPOUSE

4. Date of marriage *(Month, day, year)*	5. Place of marriage *(City, State)*	6. Marriage was performed by ☐ Clergyman or Justice of the Peace ☐ Other, *Specify* →

7. Was this marriage ended by divorce?

☐ Yes, Give → | 7a. Date of divorce *(Month, day, year)* | 7b. Place of divorce *(City, State)*
☐ No

Complete blanks 8-11 if deceased is your CHILD

8. Child's marital status	9. Child's relationship to you		
☐ Single	☐ Legitimate child	☐ Step child	☐ Other *(Specify below)*
☐ Married	☐ Adopted child	☐ Recognized natural child	

10. If the deceased was a stepchild or recognized natural child, was child living with you at the time of death?	11. If the deceased was a recognized natural child and was not living with you at the time of death, did you provide financial support for the child?
☐ Yes	☐ No
☐ No — Explain:	☐ Yes — Explain:

Part C — Certification By the Insured

I hereby certify that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld.

1. Signature of insured *(Do not print)*	2. Date *(Month, day, year)*	3. Telephone number *(including area code)*

4. Full name of insured *(Type or print)*	**Warning:** Any intentional false statement in the claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001)

5. Mailing address *(Number, street, city, state and ZIP code)*

Part D — Certification of Insurance Status

ACTIVE Employees — to be completed by employing agency
FORMER Employees who are RETIREES or COMPENSATIONERS — to be completed by the Office of Personnel Management

1. Was employee covered under Option C-Family on the date of death of family member		2. If employee was retired or receiving compensation give the information below:	
☐ Yes — Give →	1a. Effective date of election	2a. Date of retirement (Mo. day, yr.)	2b. Date of birth (Mo. day, yr.)
☐ No			

I certify that the above information given in Part D has been obtained from, and correctly reflects, official records and the employee named was covered by Federal Employees' Option C-Family Life Insurance on the date of the death.

3. Signature of authorized agency official	4. Name of agency

5. Name of authorized agency official *(Type or Print)*	6. Mailing address of agency, including ZIP Code

7. Title	

8. Date signed *(Month, day, year)*	9. Commercial telephone number *(including area code)*

Instructions to Claimant

1. **To avoid delay:**

   (a) Read these instructions carefully.
   (b) Type or print in ink.

2. **Completion of Claim –**

   PARTS A, B and C should be completed by the claimant (usually the insured employee).

3. **Evidence Required –**

   There must be submitted with this claim a certified copy of the death certificate. This record may be obtained from the Bureau of Vital Statistics or equivalent agency. Failure to submit death certificate will delay settlement of claim. Additional evidence may be required.

4. **If Assistance is Needed –**

   If you need assistance in completing this claim, contact the local personnel office of the department or agency in which you are or had been last employed or the Office of Federal Employees' Group Life Insurance, 4 East 24th Street New York, N.Y. 10010.

5. **Where to Send Claim –**

   Forward completed claim to the local personnel office of the department or agency in which you are employed. If you are retired or receiving Federal Workers' Compensation, forward completed claim form and the death certificate to: Office of Personnel Management, Retirement and Insurance Programs, Washington, D.C. 20415.

A REMINDER TO ACTIVE EMPLOYEES AND FORMER EMPLOYEES WHO ARE RETIREES OR COMPENSATIONERS UNDER AGE 65

Arrangements should be made to discontinue withholdings for Family Life Insurance when an insured no longer has eligible family members.

Active Employees – Consult your employing office.

Former Employees who are **Retirees or Compensationers** – write to the Office of Personnel Management, Retirement and Insurance Programs, Washington, D.C. 20415.